ILLINOIS WORKERS' COMPENSATION COMMISSION

Accident Reporting System

Electronic Data Interchange Information Packet

Last Revised May 2009

ILLINOIS WORKERS' COMPENSATION COMMISSION
100 W. RANDOLPH ST. #8-200
CHICAGO, IL 60601
BENNIE HORTON, JR., EDI COORDINATOR
312/814-6179
BENNIE.HORTON@ILLINOIS.GOV

ELECTRONIC DATA INTERCHANGE

We welcome your participation in the electronic exchange of accident report data. We have worked with the International Association of Industrial Accident Boards and Commissions (IAIABC) to develop a layout for accident reports that is used by many carriers and self-insurers.

Currently, we can only accept the *First Report of Injury* electronically. Our standard format is attached. It shows the IAIABC groupings as well as their elements and sources.

We accept transmissions through two vendors: GXS/IBMIS (877/326-6426, option 3, then option 1) and Peak Performance (866/448-1776, press option 1). The Commission does not assume any transmission charges.

Once we receive a transmission, we will send you a confirmation. If we find errors, we will send you a printout, listing the fields that are in error. If you have an error, please resend your corrected record with a "02" in the 4th and 5th positions, which is the field, "Transaction Set Purpose Code." We have made every effort to make this process run smoothly, but we do invite your suggestions for improvement.

If you have any questions, or are ready to start transmitting data electronically, please call Bennie Horton, Jr., at 312/814-6179. We look forward to working with you.

Illinois Workers' Compensation Commission

ACCIDENT REPORTING PROVISIONS
UNDER THE
ILLINOIS WORKERS' COMPENSATION ACT
820 ILCS 305/6

Section 6(b). Every employer subject to this Act shall maintain accurate records of work-related deaths, injuries and illness other than minor injuries requiring only first aid treatment and which do not involve medical treatment, loss of consciousness, restriction of work or motion, or transfer to another job and file with the Commission, in writing, a report of all accidental deaths, injuries and illnesses arising out of and in the course of the employment resulting in the loss of more than 3 scheduled work days. In the case of death such report shall be made no later than 2 working days following the accidental death. In all other cases such report shall be made between the 15th and 25th of each month unless required to be made sooner by rule of the Commission. In case the injury results in permanent disability, a further report shall be made as soon as it is determined that such permanent disability has resulted or will result from the injury.

All reports shall state the date of the injury, including the time of day or night, the nature of the employer's business, the name, address, age, sex, conjugal condition of the injured person, the specific occupation of the injured person, the direct cause of the injury and the nature of the accident, the character of the injury, the length of disability, and in case of death the length of disability before death, the wages of the injured person, whether compensation has been paid to the injured person, or to his or her legal representative or his heirs or next of kin, the amount of compensation paid, the amount paid for physicians', surgeons' and hospital bills, and by whom paid, and the amount paid for funeral or burial expenses if known. The reports shall be made on forms and in the manner as prescribed by the Commission and shall contain such further information as the Commission shall deem necessary and require.

The making of these reports releases the employer from making such reports to any other officer of the State and shall satisfy the reporting provisions as contained in the "Health and Safety Act" and "An Act in relation to safety inspections and education in industrial and commercial establishments and to repeal an Act therein named", approved July 18, 1955, as now or hereafter amended. The reports filed with the Commission pursuant to this Section shall be made available by the Commission to the Director of Labor or his representatives and to all other departments of the State of Illinois, which shall require such information for the proper discharge of their official duties. Failure to file with the Commission any of the reports required in this Section is a petty offense.

Except as provided in this paragraph, all reports filed hereunder shall be confidential and any person having access to such records filed with the Industrial Commission as herein required, who shall release any information therein contained including the names or otherwise identify any persons sustaining injuries or disabilities, or give access to such information to any unauthorized person, shall be subject to discipline or discharge, and in addition shall be guilty of a Class B misdemeanor.

The Commission shall compile and distribute to interested persons aggregate statistics, taken from the reports filed hereunder. The aggregate statistics shall not give the names or otherwise identify persons sustaining injuries or disabilities or the employer of any injured or disabled person.

(Source: P.A. 84-981)

Note: Effective January 1, 2005, the Illinois Industrial Commission became the Illinois Workers' Compensation Commission. The law states that any reference to the Industrial Commission should be considered a reference to the Workers' Compensation Commission.

IAIABC FLAT FILE FORMAT IAIABC EDT STANDARD

GROUPING	IAIABC ELEMENTS	ELEMENT SOURCE	IWCC RULES	FORMAT	POSITION BEG	POSITION END	CONVERSION RULES INPUT	CONVERSION RULES OUTPUT
Transaction	Transaction Set ID	ANSI 143	REQ	3 A/N	1	3	'148' NA	'IC45' '1'
Transaction	Transaction Set Purpose Code	ANSI 353	REQ	2 A/N	4	5	' 00 '	'N' , else 'R'
Transaction	Transaction Set Date	IAIABC	OPT	DATE	6	13	CCYYMMDD	MM-DD-CC-YY
Claimant	Social Security Number	DCI FLD 10	REQ	9 A/N	659	667	XXXXXXXXX	XXX-XX-X-XXX
Accident	Date of Injury	IAIABC	REQ	DATE	463	470	CCYYMMDD	MM-DD-CC-YY
Accident	Agency Claim Number	IAIABC	OPT	25 A/N	16	40		LEFT 10 POS.
Accident	Time of Injury	IAIABC	REQ	HHMM	471	474		Same
Insured	Employer Code FEIN	IAIABC	REQ	9 A/N	230	238	XXXXXXXXX	XX-XXXXXXX
Insured	Employer Name	IAIABC	REQ	30 A/N	269	298		Same
Insured	Employer Address Line 1	IAIABC	OPT	30 A/N	299	328		Same
Insured	Employer Address Line 2	IAIABC	OPT	30 A/N	329	358		Same
Insured	Employer City	IAIABC	OPT	15 A/N	359	373		Same
Insured	Employer State	IAIABC	OPT	2 A/N	374	375		Same
Insured	Employer Postal Code Zip	IAIABC	OPT	5 A/N	376	380		Same
Insured	Employer Postal Code Plus 4	IAIABC	OPT	4 A/N	381	384		Same
Claim Admin.	Claim Admin. Code FEIN	IAIABC	REQ	9 A/N	41	49	XXXXXXXXX	XX-XXXXXXX
Policy	Policy Number	DCI FLD 10	OPT	30 A/N	417	446		Left 18 CHAR.
Policy	Claimant Last Name	IAIABC	REQ	30 A/N	668	697		Same
Policy	Claimant First Name	IAIABC	REQ	15 A/N	698	712		Left 14 CHAR.
Policy	Claimant Middle Initial	IAIABC	OPT	1 A/N	713	713		Same
Policy	Claimant Address Line 1	IAIABC	REQ	30 A/N	714	743		Same
Policy	Claimant Address Line 2	IAIABC	OPT	30 A/N	744	773		Same
Policy	Claimant City	IAIABC	REQ	15 A/N	774	788		Same
Policy	Claimant State	IAIABC	REQ	2 A/N	789	790		Same

REQ = REQUIRED

OPT = OPTIONAL

IAIABC FLAT FILE FORMAT IAIABC EDT STANDARD

GROUPING	IAIABC ELEMENTS	ELEMENT SOURCE	IWCC RULES	FORMAT	POSITION BEG	POSITION END	CONVERSION RULES INPUT	CONVERSION RULES OUTPUT
Policy	Claimant Postal Code Zip	IAIABC	REQ	5 A/N	791	795		Same
Policy	Claimant Postal Code + 4	IAIABC	OPT	4 A/N	796	799		Same
Policy	Marital Status Code - S,M	ANSI 1067	REQ	1 A/N	819	819	'M'	'M' , else 'S'
Policy	Date of Birth	IAIABC	OPT	DATE	810	817	CCYYMMDD	MM-DD-CC-YY
Policy	Gender Code - F,M,or U	ANSI 1068	REQ	1 A/N	818	818	'F'	'F' , else 'M'
Policy	Number of Dependents	IAIABC	OPT	2 N	820	821		Same
Policy	Date of Death	IAIABC	REQ	DATE	830	837	CCYYMMDD	MM-DD-CC-YY
Policy	Wage	IAIABC	REQ	S9.2	882	892		Same
Policy	Date Last Day Worked	IAIABC	OPT	DATE	896	903	CCYYMMDD	MM-DD-CC-YY
Policy	Date Reported to Employer	IAIABC	OPT	DATE	643	650	CCYYMMDD	MM-DD-CC-YY
Policy	Date of Return to Work	IAIABC	OPT	DATE	906	913	CCYYMMDD	MM-DD-CC-YY
Policy	Employer's Premises Indicator	IAIABC	OPT	1 A/N	484	484		Same
Policy	Sic Code	IAIABC	REQ	6 A/N	386	391		Left 4 Digits
Policy	Class Code	DCI FLD 23	REQ	4 A/N	840	843		Same
Policy	Part of Body Injured Code	DCI FLD 24	REQ	2 A/N	487	488		Same
Policy	Nature of Injury Code	DCI FLD 25	REQ	2 A/N	485	486		Same
Policy	Cause of Injury Code	DCI FLD 26	REQ	2 A/N	489	490		Same
Policy	Accident Description / Cause	IAIABC	REQ	150A/N	491	640	NA	Left 10 Char. Blanks
Policy	Postal Code of Injury Site Zip	IAIABC	OPT	5 A/N	475	479		Same
Policy	Postal Code of Injury Site + 4	IAIABC	OPT	4 A/N	480	483		Same

REQ = REQUIRED

OPT = OPTIONAL

IAIABC FLAT FILE FORMAT IAIABC EDT STANDARD

GROUPING	IAIABC ELEMENTS	ELEMENT SOURCE	IWCC RULES	FORMAT	POSITION BEG	POSITION END	CONVERSION RULES INPUT	CONVERSION RULES OUTPUT
Policy	Initial Treatment	IAIABC	OPT	2 A/N	641	642	NA NA NA	'N' Blanks 'N' Blanks
Jurisdiction	Jurisdiction	IAIABC	OPT	2 A/N	14	15		NA
Jurisdiction	Insured Name	IAIABC	OPT	30 A/N	239	268		NA
Jurisdiction	Self Insured Indicator	IAIABC	REQ	1 A/N	385	385		
Jurisdiction	Claim Admin. Name	IAIABC	OPT	30 A/N	50	79		NA
Jurisdiction	Policy Effective	IAIABC	OPT	DATE	447	454		NA
Jurisdiction	Claimant Phone	IAIABC	OPT	10 A/N	800	809		NA
Jurisdiction	Date Disability Began	IAIABC	OPT	DATE	822	829		NA
Employment	Employment Status Code	IAIABC	OPT	2 A/N	838	839		NA
Employment	Wage Period	IAIABC / DISAB	OPT	2 A/N	893	894		NA
Employment	Full Wages Paid for Date of Injury	IAIABC	OPT	1 A/N	904	904		NA
Employment	Date Reported to Claims Admin.	DCI FLD 9	OPT	DATE	651	658		NA
Employment	Insured Report Number	IAIABC	OPT	10 A/N	392	401		NA
Employment	Occupation Description	IAIABC	OPT	30 A/N	844	873		NA
Employment	Independent Adjuster Code	IAIABC	OPT	9 A/N	80	88		NA
Employment	Policy Expiration	IAIABC	OPT	DATE	455	462		NA
Employment	Number of Days Worked	IAIABC / ANSI	OPT	1 N	895	895		NA
Employment	Salary Continued Indicator	IAIABC	OPT	1 A/N	905	905		NA
Employment	Insured Location Number	IAIABC	OPT	15 A/N	402	416		NA
Employment	Date of Hire	IAIABC	OPT	DATE	874	881		NA
Employment	Independent Adjuster Name	IAIABC	OPT	30 A/N	89	118		NA
Employment	Claim Admin. Address Line 1	IAIABC	OPT	30 A/N	119	148		NA
Employment	Claim Admin. Address Line 2	IAIABC	OPT	30 A/N	149	178		NA
Employment	Claim Admin. Address City	IAIABC	OPT	15 A/N	179	193		NA
Employment	Claim Admin. Address State	IAIABC	OPT	2 A/N	194	195		NA
Employment	Claim Admin. Address Postal Code	IAIABC	OPT	9 A/N	196	204		NA
Employment	Claim Admin. Claim Number	IAIABC	OPT	25 A/N	205	229		NA

REQ = REQUIRED

OPT = OPTIONAL